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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS-10450, CMS-10078]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the Agency's function; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. Type of Information Collection Request: New collection; Title: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for Physician Quality Reporting; Use: The Physician Quality Reporting System (PQRS) was established in 2006 as a voluntary "pay-for-reporting" program that allows physicians and other eligible healthcare professionals to report information to Medicare about the quality of care provided to beneficiaries who have certain medical conditions. The PQRS provides incentive payments to physicians who report quality data. Since the program's inception, these results have not been publicly available for use by consumers.

The Physician Compare Web site was launched December 30, 2010, to meet requirements set forth by Section 10331 of the Affordable Care Act (ACA). The ACA requires CMS to establish a Physician Compare website by January 1, 2011, containing information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting Initiative. By no later than January 1, 2013 (and for reporting periods beginning no earlier than January 1, 2012), CMS is required to implement a plan to make information on physician performance publicly available through Physician Compare. A key component of the reporting requirements under the ACA is public reporting on physician performance that includes patient experience measures. The collection and reporting of a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Physician Quality Reporting will fulfill this requirement.

The U.S. Department of Health and Human Services (HHS) has developed the National Quality Strategy that was called for under the ACA to create national aims and priorities to guide local, state, and national efforts to improve the quality of health care. This strategy has established six priorities that support the three-part aim. The three-part aim focuses on better care, better health, and lower costs through improvement. The six priorities include: making care safer by reducing harm caused by the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care

delivery models. The CAHPS Survey for Physician Quality Reporting focuses on patient experience. Implementation of the survey supports the six national priorities for improving care, particularly engaging patients and families in care and promoting effective communication and coordination.

This survey supports the administration of the Quality Improvement Organizations Program (QIO). The Social Security Act, as set forth in Part B of Title XI - Section 1862(g), established the Utilization and Quality Control Peer Review Organization Program, now known as the QIO Program. The statutory mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. This survey will provide patient experience of care data that is an essential component of assessing the quality of services delivered to Medicare beneficiaries. It also would permit beneficiaries to have this information to help them choose health care providers that provide services that meet their needs and preferences, thus encouraging providers to improve quality of care that Medicare beneficiaries receive. Form Number: CMS-10450 (OCN: 0938-New); Frequency: Annual; Affected Public: Individuals and Households; Number of Respondents: 234,600 Total Annual Responses: 117,300; Total Annual Hours: 39,530. (For policy questions regarding this collection contact Regina Chell at 410-786-6551. For all other issues call 410-786-1326.)

2. Type of Information Collection Request: Reinstatement of a previously approved collection; Title: Program for Matching Grants to States for the Operation of High Risk Pools; Use: The Centers for Medicare and Medicaid Services (CMS) is requiring the information in this information collection request as a condition of eligibility for grants that were authorized in the Trade Act of 2002, the Deficit Reduction Act of 2005 and the State High Risk Pool Funding

Extension Act of 2006. The information is necessary to determine if a State applicant meets the necessary eligibility criteria for a grant as required by law. The respondents will be States that have a high risk pool as defined in sections 2741, 2744, or 2745 of the Public Health Service Act. The grants will provide funds to States that incur losses in the operation of high risk pools. High risk pools are set up by States to provide health insurance to individuals that cannot obtain health insurance in the private market because of a history of illness; Form Number: CMS-10078 (OCN: 0938-0887); Frequency: Occasionally; Affected Public: State, Local and Tribal Governments; Number of Respondents: 31; Total Annual Responses: 31; Total Annual Hours: 1,240. (For policy questions regarding this collection contact Paul Scholz at (410) 786-6178. For all other issues call (410) 786-1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web Site address at <http://www.cms.hhs.gov/PaperworkReductionActof1995>, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office on (410) 786-1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on **[insert date 30 days after date of publication in the Federal Register.]**

OMB, Office of Information and Regulatory Affairs

Attention: CMS Desk Officer

Fax Number: (202) 395-6974

E-mail: OIRA_submission@omb.eop.gov

Dated: March 19, 2013

Martique Jones

Deputy Director, Regulations Development Group

Office of Strategic Operations and Regulatory Affairs

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